Toward integrated medical resource policies for Canada: 6. Remuneration of physicians and global expenditure policy

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This is the sixth in a series of articles[1-5] describing the report *Toward Integrated Medical Resource Policies for Canada*,* prepared for the Federal/Provincial/Territorial Conference of Deputy Ministers of Health,[6-8] and the third to address a specific policy area.[4,5]

This article deals with two related subjects: the remuneration of physicians and global expenditure policy. The latter goes beyond the physician resources sector; however, physicians both directly and indirectly influence overall health care expenditures. These issues are discussed extensively in the report.[9] Here, we identify the main problems and describe briefly the policy directions suggested. Not covered are the ongoing discussions and the major policy developments in some provinces since the report was completed, in May 1991.

Remuneration of physicians

All stakeholder groups that we interviewed identified this as a major problem, although not for the same reasons. Representatives of medical associations and associations of interns and residents questioned the fairness of the current processes of fee bargaining and allocation and their effect on the level and distribution of income within the medical profession. Most other groups (including deans of medicine and representatives of affiliated teaching hospitals, provincial licensing authorities and provincial governments) cited the fee-for-service method of payment as the fundamental problem with remuneration.

It is not surprising that this topic is characterized by strongly held and differing views: although the specific issues may have changed over the years, physician remuneration has been a controversial subject since the introduction of publicly financed medical insurance, and the controversy shows no signs of abating.[10,11]

In our view the main problems include the following: (a) fair remuneration for the provision of medical care, (b) the political, human and financial costs of fee or income negotiations, (c) the lack of incentives to deploy physician resources efficiently, (d) the linkages between fee-for-service payment and increased use of medical services, and (e) the effect of fee-for-service payment on the relationship between hospitals and the physicians who use them.

Fair remuneration

There is a widespread feeling that the current processes of fee bargaining, internal allocation of fee changes and adjustments for changes in the costs of practice do not provide incomes that are reasonable and equitable within the medical profession. Rightly or wrongly this is a dominant concern of the profes-

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sion and as such a fundamental problem in physician remuneration and in the entire area of physician resource policy.

The problem has at least three components: dispute resolution, internal equity and overhead costs. The absence of an accepted method of dispute resolution dates back to the beginnings of Canadian medicare and was reaffirmed as an issue in the 1980 Hall review.[12] Many physicians and observers feel that "policy honesty" is involved. Although some of Hall's recommendations, such as the elimination of extra-billing, have been enacted, the *quid pro quo* of acceptable mechanisms for dispute resolution has failed to materialize in certain jurisdictions. The joint management structures developed recently in some provinces may reduce the importance of this issue, but it remains a source of dissatisfaction in others.

Regarding internal equity, members of the profession and provincial ministries of health are concerned about various inequities in provincial fee schedules, including interspecialty differences in implicit hourly "wages" and the slow pace of adjustment of fees to the diffusion of new procedures and technologies. For the profession this results in interspecialty conflicts over relative incomes.[13-15] For ministries of health the concern is much broader and linked to other issues. In particular, the perception is that fee-schedule inequities promote undesirable utilization patterns (for example, a rapid increase in procedures) as well as choices of specialty (and therefore often of geographic location) that do not match population needs.

Finally, there continues to be disagreement on a reasonable treatment of overhead costs in fee-for-service remuneration. The profession generally feels that fee changes do not take adequate account of the increasing costs of practice, and the payers feel that the costs of practice are in part a function of the ways in which physicians choose to organize and operate their practices. Some of the costs of practice are fixed overhead, yet fee increases are applied regardless of the number of procedures or services provided.

Costs of fee or income negotiations

There is widespread agreement (including our own) that the current methods of determining fee levels are politically risky (for all parties) and costly in terms of the human resources devoted to what is, when all the fanfare and media coverage is stripped away, essentially unproductive activity. Both sides have staff employed to do little beyond preparing for and being involved in this ritual war dance. Although all employers and employees go through some similar process the negotiation of medical fees or incomes is probably the most politically charged in the country. Is this a problem or simply part of the Canadian health care landscape by design?[16-18] We argue that it is a problem if other means of negotiation would consume fewer resources. Unfortunately, we have no information on the comparable costs of alternative mechanisms.

Lack of incentives for efficiency

There is little if anything in the manner in which physicians are paid that promotes efficiency in the provision of medical care. One example of this is the lack of incentives (in a system characterized by an abundant supply of physicians and solo fee-for-service practice) to employ less costly personnel to perform some services under supervision. Another example is the extent to which specialists (e.g., pediatricians, obstetricians and internists), particularly in urban settings, are involved in delivering primary care. Even if this care is reimbursed at the level of general practice there is distortion in the efficient supply and geographic distribution of physicians and the use of their services, as well as intraprofessional "turf wars."

Effect of fee-for-service remuneration on use of services

That fee-for-service remuneration promotes the delivery of medical care in discrete pieces and encourages the proliferation of those pieces is a story as old as the debate over alternative methods of payment. Any considered examination of the incentives inherent in the fee-for-service method acknowledges the potential for the proliferation of services, and physicians, health services researchers, payers and policymakers increasingly agree that such proliferation does occur.[19-25] (The evolution of Canadian fee negotiations reflects a growing recognition that such negotiations are not equivalent to income or expenditure negotiations.[26]) It would be unnatural if such proliferation did not occur, and those who persist in arguing that fee-for-service payment has *no* effect on the level of service provision seem increasingly difficult to take seriously.[27] The disagreement is on the extent of "induced utilization," the circumstances in which it is most likely to occur and, perhaps most important and least researched, whether such utilization contributes to the improved health status of patients.

Effect of fee-for-service remuneration on physician-hospital relationships

Interviewees repeatedly pointed out that a system in which physicians are reimbursed by fees for

specific activities, many of which require access to complementary facilities in institutions reimbursed on a different basis (and with different incentives), will create problems. Hospital managers must ensure that their institutions are run efficiently to fulfil community expectations within negotiated global budgets. Physicians using the facilities to care for their patients incur no practice costs but do create costs for the hospital. There are usually no lines of cost accountability between the physicians and the institutions. In short, the incentives for physicians and hospitals are incompatible.

Policy directions

The relation of remuneration to other policy areas is complex (for example, incentives for task delegation will likely require changes to the legislation governing scope of practice), and negotiation of any form of remuneration will never be without cost. Moreover, there is no single, best method of payment and no objective way of determining the optimum mix of payment approaches. All methods have strengths and weaknesses and require complementary policies to monitor and offset areas of weak performance.[22,28] None does well on all the criteria that may be important to funding agencies, patients and physicians themselves; therein lies the problem.

Nevertheless, in our view it is time for a national reconsideration of the fee-for-service method of payment to examine its appropriateness for different types of service and to move toward a more mixed system of remuneration models. A fundamental principle would be that remuneration methods should contribute to (or at least not impede) the achievement of the objectives of physician resource policy described in chapter 3 of our report[7] and in an earlier article in this series.[2]

One of the areas that might justifiably be included in the first round of reform in remuneration policy is fee-for-service payment for academic clinical practice, which was discussed in the article on the roles and funding of academic medical centres.[5] There is no obvious rationale for reimbursing the supervision of medical students on the basis of fees for the services provided under supervision. Moreover, such a method of payment does not match well with broader educational objectives, especially given the current financial pressure on academic medical centres and their increasing reliance on clinical earnings as a major source of operating revenue.

Primary care should be another focus in the first round of payment reform. The objective of a primary care physician is to serve as the frontline provider and entry point for particular patients and to manage their overall care through a combination of personal care and referral to other services and providers as needed. The payment of fees for particular services is neither an effective nor an efficient way to encourage and reward the management and gatekeeper functions. Much more serious consideration needs to be given to capitation payment models or mixed capitation plus limited fee-for-service models.

Other clinical areas that might be included in a first round of payment reform are specialized tertiary or quaternary services and emergency care. We do not wish to suggest that arriving at arrangements satisfactory to all parties would be a trivial process in any of these clinical areas; however, alternatives to the fee-for-service model may be more appropriate for the management of such services.

More examples to be included in the reconsideration of remuneration methods are provided in section 6B of our report.[7]

As with any major policy development, changes to methods of payment will require sensitivity and should be generated collaboratively by the funding agencies and the professionals affected. Reasonable times and paths will need to be established for the adjustments. However, the direction of change appears clear, and the need to initiate change on the basis of careful review should not be a justification for indefinite delay.

When the fee-for-service method is deemed appropriate there should be greater attention paid to the implicit relative values assigned to different services and activities, the mechanisms (or lack thereof) for relativity adjustment and the types of factors that should be taken into account in the establishment of fee relativities. Extensive work has been undertaken on the subject of fee relativity in the United States,[29-32] and the subject is under active consideration by medical associations in Canada. We encourage efforts to structure fee relativities that recognize the value of professional time (to include factors such as length of training, uniqueness of skills, complexity and uncertainty of the knowledge base, and working conditions), the extent to which the skills of the professional are indispensable to the performance of the service, and the costs of the complementary resources or input for which the practitioner is responsible (with account taken of the efficiency with which practices are organized and the situations in which at least some of the overhead costs are provided publicly).

We recognize the complexity of attempting to develop and monitor fee relativities that embody these factors, and we encourage interregional collaboration. Furthermore, we favour the idea of establishing consistency across regions in relative (not absolute) fees.

An important component of the restructuring of payment for physician services will be the develop-

ment of more broadly conceived master agreements (or their equivalents) that address not only the structures and processes for negotiating reasonable levels of remuneration (regardless of the method of payment) but also other interrelated physician-resource issues. Methods for resolving financial disputes will be a critical aspect of these agreements. However, the mix of other factors to be dealt with (e.g., utilization, physician supply and quality assurance) and how disputes about each are to be resolved (binding arbitration v. other models) will also be key issues in the development of these new agreements.

Global expenditure policy

The fundamental problem for global expenditure policy is that the largely open-ended nature of remuneration for medical services undermines budgetary predictability for public officials. Attempting to stay within budget remains a constant source of pressure on politicians; they are loath to raise taxes and are limited by the Canada Health Act in their ability to increase private sources of revenue, yet they see rising medical expenditures impinging on or precluding other high-priority programs both within and outside the health sector.

Fee-for-service payment, especially during times of rapidly increasing physician supply, is a major contributor to this problem. It is incompatible with the control of long-term global expenditures when (a) only fee (as opposed to income) levels are predetermined, (b) physician supply, use of services by patients and the number of patients are floating variables, and (c) payment is made on the basis of process and is frequently independent of considerations of outcome or effectiveness.

There are, of course, other factors that contribute to the unpredictability of medical expenditures, such as population growth, demographic change and the unpredictability of illness itself. In our view, however, the role of these factors is overemphasized in popular and policy discussion of expenditure dynamics. Population growth and demographic change are relatively slow-moving and predictable; their effects can easily be taken into account in budget development. In fact, the main danger in forecasting such effects is that changes in patterns of utilization and service *provision* will be incorporated without scrutiny into the process of demographic adjustment and will thereby be confused with increases in utilization attributable to demographic shifts.

For example, a common view is that the aging of the population will cause the need for physicians and medical expenditures to increase dramatically in the future. Yet, even leaving aside the important question of whether we want to care for our elderly with a different mix of health care professionals (or other types of providers), all analyses of the "aging crisis" to date consistently demonstrate that the impact of changes in only the *number* of elderly people will be relatively small, can be accommodated by very modest economic growth and is dwarfed by recent increases in age-adjusted, per capita service provision for the elderly.[33-37]

As for unpredictability in expenditures due to changes in the incidence of illness itself, unless populations are steadily becoming less healthy one might expect to see fluctuations around average age-specific patterns of utilization. This is not the case — the changes have all been increases in utilization.

A sophisticated and comprehensive analysis of the forces driving medical expenditures is not our intent. Clearly, there are several important influences, including the expectations of patients and the availability of and reliance on new technology, which themselves require policy attention. Furthermore, although provincial governments act as if the public were unwilling to spend more on medical care there is little information on what a fully informed public might wish to spend on health in general and on the medical care component in particular.

Nevertheless, we found a growing consensus across the country (including in the medical profession) on the need for budgetary control and reasonable predictability within a largely publicly financed health care system. In the budgetary process short-term allocative decisions and trade-offs are considered on behalf of the public. Open-ended programs maintain an uncomfortable existence in this type of environment and impose costs on other programs without the public or its representatives having been able to choose the new expenditure levels.

Efforts to improve the effectiveness and efficiency of medical care through evaluative studies, quality assurance programs, practice guidelines and technology assessment do not remove the need for responsible budgeting and fiscal choices.[38] These activities are important — indeed essential — and should play a major role in determining the use of resources within the amount allocated to medical care. They should be insisted on by responsible payers; but in themselves they will not determine the broader distribution of funds between health care and other valued public activities. This determination is a social judgement to be made through a political process, not a technical judgement to be made by experts. Therefore, quality of care and public accountability would be best served if jurisdictions moved toward systems of health and medical care resource allocation consisting of "top-down" budgetary allocative processes and "bottom-up" evaluative and corrective processes.

Again, there will likely be no single best model of budgetary allocation and control. Provinces and territories use various models, and other models, including considerably more decentralized ones, are under discussion at present across the country in response to the recommendations from several provincial panels and commissions. Although improved mechanisms are needed in the decentralized models for transferring to the public needed information about the costs, effects and benefits of alternative allocations, some form of decentralized budgetary control and accountability may in the long run be the only practical way to respond to differences among communities in needs and preferences.

One option that is complementary to controlling global expenditure is an income threshold policy. We found surprisingly widespread support for such an initiative across stakeholders, including physicians. Many physicians as well as observers outside the profession apparently feel that a substantial number of practitioners have gross billings incompatible with the provision of high-quality care.

We do not find individual income thresholds a particularly appealing policy option, except as a "last best" (or perhaps "first but temporary") instrument to stimulate a more constructive and collaborative development of other policies to manage physician resources. If quality of care is an issue, then an improved system of continuing competence assessment seems to us a preferable policy. If proliferation of services is a concern, then decreased reliance on the fee-for-service method seems preferable. We share the widely held concerns about the current levels and distribution of physicians' incomes; however, we also share concerns that thresholds, unless carefully designed, may "penalize the good guys." An integrated set of revisions to quality assurance, remuneration method and physician supply policies should be the objective here.

Regardless of the specific components, some form of global budgetary or expenditure control policy — perhaps with increased education and involvement of the public — is a necessary part of a responsible policy package in all jurisdictions. The failure of all regions of Canada to engage in this will invite interregional backlash and "whipsawing"; it will also severely impede the development of a national strategy for the overall management of physician resources that addresses other important, nonfinancial issues.

Although the views expressed here and in the report *Toward Integrated Medical Resource Policies for Canada* are entirely the authors' responsibility the sections of the report on which this article is based benefitted from discussions with Jonathan Lomas and Roberta Labelle.

References

1. Barer ML, Stoddart GL: Toward integrated medical resource policies for Canada: 1. Background, process and perceived problems. *Can Med Assoc J* 1992; 146: 347-351
2. Stoddart GL, Barer ML: Toward integrated medical resource policies for Canada: 2. Promoting change — general themes. Ibid: 697-700
3. Idem: Toward integrated medical resource policies for Canada: 3. Analytic framework for policy development. Ibid: 1169-1174
4. Barer ML, Stoddart GL: Toward integrated medical resource policies for Canada: 4. Graduates of foreign medical schools. Ibid: 1549-1554
5. Stoddart GL, Barer ML: Toward integrated medical resource policies for Canada: 5. The roles and funding of academic medical centres. Ibid: 1919-1924
6. Barer ML, Stoddart GL: *Toward Integrated Medical Resource Policies for Canada.* Prepared for the Federal/Provincial/Territorial Conference of Deputy Ministers of Health, 1991
7. Idem: *Toward Integrated Medical Resource Policies for Canada: Background Document*, University of British Columbia (HPRU discussion paper 91:6D), Vancouver, and McMaster University (CHEPA working paper 91-7), Hamilton, Ont, 1991
8. Idem: *Toward Integrated Medical Resource Policies for Canada: Appendices*, University of British Columbia (HPRU discussion paper 91:7D), Vancouver, and McMaster University (CHEPA working paper 91-8), Hamilton, Ont, 1991
9. Idem: *Toward Integrated Medical Resource Policies for Canada: Background Document*, University of British Columbia (HPRU discussion paper 91:6D), Vancouver, and McMaster University (CHEPA working paper 91-7), Hamilton, Ont, 1991: 4A (24-26), 4C (56-69), 5A (21-26), 6B (74-96)
10. Wright CJ: The fee-for-service system should be replaced. *Can Med Assoc J* 1991; 144: 900-901, 903
11. Baltzan MA: The fee-for-service system should be replaced [C]. *Can Med Assoc J* 1991; 145: 763-765
12. Hall EM: *Canada's National-Provincial Health Program for the 1980's*, Craft Litho Ltd, Saskatoon, 1980
13. Discrepancy between specialist and GP incomes major issue facing new BCMA president. *Can Med Assoc J* 1986; 135: 375
14. Remuneration, encroachment by specialists among concerns of GPs. Ibid: 1020-1024
15. Income disparities still a hot issue for doctors. *Med Post* 1986; 22 (44): 46
16. Evans RG, Lomas J, Barer ML et al: Controlling health expenditures — the Canadian reality. *N Engl J Med* 1989; 320: 571-577
17. Barer ML, Evans RG, Labelle RJ: Fee controls as cost control: tales from the frozen North. *Milbank Q* 1988; 66: 1-64
18. Tuohy C: Conflict and accommodation in the Canadian health care system. In Evans RG, Stoddart GL (eds): *Medicare at Maturity: Achievements, Lessons, and Challenges*, U of Calgary Pr, Calgary, 1986: 393-434
19. Watanabe M: Utilization studies: the Alberta experience. *ACMC Forum* 1990; 23 (2): 1-11
20. Bock RS: The pressure to keep prices high at a walk-in clinic: a personal experience. *N Engl J Med* 1988; 319: 785-787
21. Krasnick A, Groenewegen PP, Pedersen PA et al: Changing remuneration systems: effects on activity in general practice. *BMJ* 1990; 300: 1698-1701
22. Rosen B: Professional reimbursement and professional behaviour: emerging issues and research challenges. *Soc Sci Med* 1989; 29: 455-462
23. Evans RG: *Squaring the Circle: Reconciling Fee-for-Service with Global Expenditure Control*, University of British Columbia (HPRU discussion paper 88:8), Vancouver, 1988
24. Lomas J, Fooks C, Rice T et al: Paying physicians in Canada:

minding our Ps and Qs. *Health Aff* 1989; 8 (1): 80-102
25. Relman AS: What market values are doing to medicine. *Atlantic Monthly* 1992; Mar: 99-106
26. Barer ML: Controlling medical care costs in Canada. *JAMA* 1991; 265: 2393-2394
27. Fuchs VR: Physician-induced demand: a parable. *J Health Econ* 1986; 5: 367
28. Hornbrook MC: Allocative medicine: efficiency, disease severity, and the payment mechanism. *Ann Am Acad Polit Soc Sci* 1983; 468: 12-29
29. Hsiao WC, Braun P, Becker ER et al: The resource-based relative value scale: toward the development of an alternative physician payment system. *JAMA* 1987; 258: 799-802
30. Hsiao WC, Braun P, Dunn D et al: Results and policy implications of the resource-based relative-value study. *N Engl J Med* 1988; 319: 881-888
31. Hsiao WC, Braun P, Yntema D: Estimating physicians' work for a resource-based relative-value scale. Ibid: 835-841
32. *Annual Report to Congress, 1990*, Physician Payment Review Commission, Washington, 1990
33. Barer ML, Evans RG, Hertzman C et al: Aging and health care utilization: new evidence on old fallacies. *Soc Sci Med* 1987; 24: 851-862
34. Barer ML, Pulcins IR, Evans RG et al: Trends in use of medical services by the elderly in British Columbia. *Can Med Assoc J* 1989; 141: 39-45
35. Denton FT, Spencer BG: Population aging and future health costs in Canada. *Can Public Pol* 1983; 9: 155-163
36. Stoddart GL: Comment on alternative modes for health care delivery. In Economic Council of Canada: *Aging with Limited Health Resources* (proceedings of a colloquium on health care), Min of Supply and Services, Ottawa, 1987: 68-71
37. Getzen TE: Population aging and the growth of health expenditures. Presented at the 10th annual meeting of the Association for Health Services Research, San Diego, July 2, 1991
38. Wennberg JE: Outcomes research, cost containment and the fear of health care rationing. *N Engl J Med* 1990; 323: 1202-1204

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